STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415035	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnwood Rehabilitation and Healthcare Center	610 Smithfield Road North Providence, RI 02904

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47939 Based on record review and staff interview it has been determined that the facility failed to protect and keep residents free from physical abuse relative to an incident that occurred between Resident ID #1 and Resident ID #2, resulting in significant injury of Resident ID #1. Findings are as follows: Record review of the facility policy titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program states in part, Residents have the right to be free from abuse .The .prevention program consists of a facility wide commitment and resource allocation to support the following objectives .Protect residents from abuse .by anyone including .other residents . According to State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, last revised ,d+[DATE], .Abuse is the willful infliction of injury .with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Resident to Resident Abuse of Any Type (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnwood Rehabilitation and Healthcare Center	610 Smithfield Road North Providence, RI 02904

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0600

Level of Harm - Actual harm

Residents Affected - Few

A resident to resident altercation should be reviewed as a potential situation of abuse .Also, when investigating an allegation of abuse between residents, the surveyor should not automatically assume that abuse did not occur, especially in cases where either or both residents have a cognitive impairment or mental disorder. Having a mental disorder or cognitive impairment does not automatically preclude a resident from engaging in deliberate or non-accidental actions. In determining whether F 600-Free from Abuse and Neglect should be cited in these situations, it is important to remember that abuse includes the term willful. The word willful means that the individual's action was deliberate (not inadvertent or accidental), regardless of whether the individual intended to inflict injury or harm. An example of a deliberate (willful) action would be a cognitively impaired resident who strikes out at a resident within his/her reach .The facility may provide evidence that it completed a resident assessment and provided care planning interventions to address a resident's distressed behaviors such as physical, sexual or verbal aggression. However, based on the presence of resident to resident altercations, if the facility did not evaluate the effectiveness of the interventions and staff did not provide immediate interventions to assure the safety of residents, then the facility did not provide sufficient protection to prevent resident to resident abuse. For example, redirection alone is not a sufficiently protective response to a resident who will not be deterred from targeting other residents for abuse once he/she has been redirected .

Record review of a community reported complaint submitted to the Rhode Island Department of Health on [DATE] alleges in part Staff lied about the death of a patient [Resident ID #1] was succumbed by [his/her] injuries that [s/he] received by a very aggressive patient .

Record review revealed Resident ID #1, the alleged victim, was admitted to the facility in April of 2024 with diagnoses including, but not limited to Parkinson's disease and lack of coordination.

Record review of a Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status was completed with a score of 14 out of 15 indicating intact cognition. Further review revealed s/he required extensive assistance of one staff for transfers and ambulation.

Record review of Resident ID #1's progress notes revealed the following:

-[DATE] at 11:16 AM: Resident sustained an unwitnessed fall. Upon arrival to the room the resident was observed on his/her left side between both beds and his/her head was under the bedside table. S/he was bleeding from the back of the head. The resident was unable to move his/her right leg and complained of right hip pain. S/he stated the black old [gender] walked into my room and was going through my belongings, when I asked [him/her] to stop and get out [s/he] pushed me and I fell . Resident ID #2 was observed in the resident's room at the time of this incident. Resident ID #1 sent to the hospital via 911.

-[DATE] at 3:55 AM: Resident ID #1 returned to facility at 3:35 AM. While at the hospital the resident was diagnosed with a right proximal femoral fracture with intertrochanteric and subtrochanteric involvement (hip fracture).

Record review of a hospital document dated [DATE] titled emergency room Visit Notes states in part, . presenting from [facility] for evaluation after an unwitnessed fall. Another resident of the facility apparently pushed [him/her] causing [him/her] to fall .[s/he] appears uncomfortable .discussed given the extent of the hip fracture that this will likely require surgery. Declined proceeding with surgery .[s/he] will be discharged back with P.O. [by mouth] Morphine .

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Lincolnwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 610 Smithfield Road North Providence, RI 02904	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review revealed the following new physician orders: -Morphine Sulfate 7.5 MG (milligrams) by mouth every 6 hours as needed -Morphine Sulfate 15 MG give two times daily for pain Record review of a Pain Level Summary revealed the resident experienced moderate pain (pain rated, 4 to 6 of 10) to severe pain (pain rated, 7 to 10 of 10) on the following dates and times: -[DATE] at 2:04 PM, 5 out of 10- Resident received the PRN dose of Morphine -[DATE] at 7:19 PM, 10 out of 10 -[DATE] at 8:24 PM, 5 out of 10 -[DATE] at 7:46 AM, 7 out of 10 Further record review of the resident's progress notes revealed the following: -[DATE] at 12:00 AM: Resident seen today with family at beside. Resident stating to this writer, my pain is , d+[DATE] and the family member stated s/he has been in increased pain after falling. Hospice was declined by the resident. -[DATE] at 11:31 AM: Resident seen by Psychiatric Nurse Practitioner for follow up after altercation with another resident. No new recommendations. -[DATE] at 9:30 PM: The Registered Nurse was called to the room and the resident was found to be unresponsive without respirations or a pulse. His/her heart sounds were absent, and his/her pupils were fixed and dilated. The resident was declared deceased at 9:07 PM. -[DATE] at 10:25 PM: The Medical Examiner was contacted to report Resident ID #1's death. The Nurse Practitioner gave an order to release the body. Record review of a psychiatric evaluation and consultation note for Resident ID #1 dated [DATE], states in part, .being seen today a follow up after resident to resident. The patient was reportedly pushed by another resident .and [s/he] fell , which required hospitalization leading to multiple lower body fractures .Endorses pain throughout the day . Record review for Resident ID #2 (alleged perpetrator) revealed s/he was admitted to the facility in March of 2022, with diagnoses including, but not limited to, Alzheimer's disease, dementia, and adjustment disorder. Record review of Resident ID #2's Admission MDS assessment dated [DATE] revealed a Brief Interview for Mental Status was completed with a score of 0 out of 15, indicating severe cognitive impairment. Record review of Resident ID #2's care plan revealed the following focus care areas: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER: Lincolnwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 610 Smithfield Road North Providence, RI 02904	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	-[DATE] states in part, I have a behavioral problem r/t [related to] Dementia with behaviors: Disruptive behavior: wandering, lack of impulse control, aggression, and refusal of care with interventions including, but not limited to, intervene as necessary to protect rights and safety of others. Monitor behavior episodes and attempt to determine underlying cause. -[DATE] and revised [DATE] states in part, I am/have the potential to demonstrate physical behaviors related to dementia, decreased impulse control with interventions including, but not limited to, When I become agitated, staff will intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggression staff to walk away calmly, and approach later and monitor/document/report to MD of danger to self or others, ([DATE])- 1:1 with staff until interdisciplinary team determines this is no longer necessary. -[DATE] states in part, I have the potential for psychosocial well being problem r/t negative interaction with another resident with interventions including, but not limited to, administer medications as ordered and consult psychiatry as needed. Record review for Resident ID #2 revealed the following: -[DATE] at 1:52 PM- Resident exhibiting disruptive behaviors at 4:00 PM. S/he was putting socks and bra in the sink and flooded the room. S/he was upsetting another resident with his/her intrusive behaviors. S/he was difficult to redirect and when staff attempted to redirect him/her, s/he became physically aggressive. -[DATE] at 1:31 PM- Resident exhibiting agitation and aggressive behaviors. S/he was angry when redirected to step aside. S/he started screaming and hitting staff. Record review of the [DATE] documentation Behavior monitoring report revealed on [DATE] during the day shift (7:00 AM - 3:00 PM) the resident was documented as physically aggressive toward others, expresses frustration and anger at others, making disruptive sounds, entering other resident's rooms or personal space and rummaging through their things. -[DATE] at 4:15 PM- Resident refusing all ADL's -[DATE] at 11:25 AM- Resident got into a physical altercation with another resident. -[DATE] at 10:08 PM- It was reported to this writer when the floor nurse called the family to report the transfer to the hospital after the altercation with another resident the family stated they were going to go to the hospital to make sure [s/he] does not get admitted . Upon the resident [return] from the hospital the [family member] was with [him/her]. -[DATE] at 10:47 PM- The resident returned to the facility and was placed on 15-minute checks. -[DATE] at 1:10 AM- Resident refused to stay in bed. S/he was going through drawers belonging to his/her roommate. Verbal redirection was provided without effect and one on one supervision (one staff member to one resident supervision) was provided. -[DATE] at 1:11 PM- Resident was observed going through the trash. When the staff attempted to redirect the resident s/he became aggressive and yelling out you are the devil. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincolnwood Rehabilitation and Healthcare Center	610 Smithfield Road North Providence, RI 02904

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	-[DATE] at 2:12 PM- Increased agitation noted. The resident was kicking, pushing and was unable to be redirected. -[DATE] at 8:17 AM- The resident was sent out for a Geri psych evaluation. Record review of a staff witness statement authored by the Nursing Assistant assigned to Resident ID #1 revealed that on [DATE] she was in the dining room when she heard a loud thump. She revealed she observed Resident ID #2 in Resident ID #1's room touching his/her personal items. Additionally, she revealed that Resident ID #1 was on the floor and bleeding badly. Record review of a 5-day investigation report submitted to the Rhode Island Department of Health on [DATE] by the facility reveals in part, [Resident ID #1's] account of the event remained consistent upon transfer to the hospital. Upon return from the hospital [Resident ID #1] was interviewed by the Administrator. When asked if the resident remember the incident [s/he] stated Yes, [Resident ID #2] came to my room and was going through my drawer. When I explained to [him/her] this was a [gender] room [s/he] went to hit me, but then I put my arms out as they are longer than [his/hers] to avoid it. Next thing I remember was being on the floor, and I yelled for help .[Resident ID #2] is monitored for behaviors of intrusive wandering and can be resistive to staff with care and redirection .and does have a remote history of behaviors aimed towards other residents .[Resident ID #1] returned to the facility that evening was diagnosed with a right hip fracture without surgical intervention due to comorbidities and the [family's] wishes .[Resident ID #1] has since expired . During a surveyor interview on [DATE] at approximately 3:35 PM with the Director of Nursing Services, she acknowledged that prior to the incident Resident ID #2 had exhibited physical aggression towards staff with redirection. Additionally, she was unable to provide evidence that Resident ID #1 was kept free from resident-to-resident abuse. Upon further interview with the Director of Nursing Services, she indicated that the following interventions were put into place after the incident: a) The facility completed a Quality Assurance and Performance Improvement Plan to review the incident and identify areas of improvement. b) The facility completed an audit of current residents that exhibit aggressive behaviors, and they identified if the appropriate treatment is in place, that the provider is aware of the behaviors and that the family is in agreement with the plan of care. c) Education was provided to all staff on how to manage residents that exhibit aggressive behaviors. d) The perpetrator in this incident was placed on a 1:1 status. S/he will remain on a 1:1 until the interdisciplinary team reassesses the efficacy of the interventions.